House Committee on Energy & Commerce – Subcommittee on Health
"Keeping the Promise: Site of Service Medicare Payment Reforms"
Wednesday, May 21, 2014 – 2123 Rayburn House Office Building

Testimony of Dr. Steven Landers, MD, MPH
President & CEO, VNA Health Group

Good Morning Chairman Pitts, Ranking Member Pallone and Distinguished Members of the House Subcommittee of Health. My name is Dr. Steven Landers, and I serve as the President and CEO of the Visiting Nurse Association (VNA) Health Group. Thank you for this opportunity to offer my perspective on how thoughtful Medicare reform can help keep the promise our nation has made to her senior citizens.

By way of brief background, I am a family doctor and geriatrician, with a particular focus on the delivery of therapeutic and palliative care to the elderly in their homes. Following my educational training at Case Western Reserve University School of Medicine and Johns Hopkins University School of Hygiene and Public Health, I served as Director of the Center for Home Care and Community Rehabilitation and Director of Post-Acute Operations for the Cleveland Clinic.

In 2012, I joined the outstanding team at VNA Health Group, the largest not-for-profit home health care provider in New Jersey and the second largest in the nation. For more than 100 years, our organization has served the most vulnerable amongst us — welcoming fragile new babies home, assisting disabled children and their parents, serving traumatically injured adults, delivering complex, specialized nursing services to seniors in the homes, and extending comfort to the terminally ill.

Today, VNAHG serves more than 100,000 individuals annually throughout New Jersey, a privilege we approach in a manner consistent with our tradition of collaboration and connectedness. Since our founding in 1912, our focus has been to serve those who are most vulnerable, through illness or social circumstance, in order that they may have a healthier, more hopeful, and dignified life.

Finally, I serve as Chairman of the Alliance for Home Health Quality and Innovation and serve on the Boards of Directors of the Community Health Accreditation Program, the American Academy of Home Care Medicine, the Greater Newark Health Coalition, the New Jersey Hospital Association Health Research and Education Trust, and the Partnership for Quality Home Healthcare. The Partnership, which I am pleased to represent here today, is a coalition of leading skilled home healthcare providers dedicated to advancing policy solutions that improve the quality of care and life for all home healthcare patients as well as greater efficiency and stronger program integrity for the Medicare program on which they depend.

Given the important focus of today's hearing, I would like to offer my perspective as both a medical professional and home healthcare provider. As this Committee knows, more than 1 million physicians, nurses, therapists and other caregivers across America are working every day to deliver complex medical services to an estimated 3.5 million Medicare home health beneficiaries. What is less commonly known is that this population one of the most vulnerable in our nation. Recently, Avalere Health conducted an analysis of the Medicare Current Beneficiary Survey (MCBS) Access to Care File, a national representative survey of the Medicare population, and found that Medicare home health beneficiaries are older, poorer, sicker and more likely to be female, minority and disabled than all other Medicare beneficiaries – combined:

Avalere Health – Home Health Beneficiary Study: Key Findings[1]	**Medicare Home Health Beneficiaries**	All Other Medicare Beneficiaries
Women	**60.07%**	53.9%
Beneficiaries aged 85+	**24.4%**	12.1%
Beneficiaries with 4+ chronic conditions	**74.7%**	48.5%
Beneficiaries needing assistance with 2+ Activities of Daily Living (ADLs)	**23.5%**	7.6%
Beneficiaries at or below 200% of Federal Poverty Level (FPL)	**66.2%**	47.9%
Beneficiaries from ethnic or racial minority population	**19.3%**	14.9%
Dual-eligible Medicare-Medicaid beneficiaries	**26.7%**	17.7%

[1] http://homehealth4america.org/media-center/attach/207-1.pdf

Members of this vulnerable population include stroke survivors who must relearn how to walk, talk and eat again, as well as senior citizens and disabled Americans with Multiple Sclerosis, Alzheimer's, chronic obstructive pulmonary disease (COPD), and other complex chronic conditions.

Skilled home healthcare is essential to these vulnerable Americans and their families – it addresses their complex clinical needs in the safety and dignity of their homes, enabling them to remain in their community rather than undergo institutionalization. On a personal level, home health professionals also serve as a ray of light in lives of these Americans, delivering medical treatment with compassion, tenderness, and professional skill that enables seniors to stay close to family and community supports.

Home healthcare is also essential to the sustainability of the Medicare program and to the millions of taxpayers who provided critical financing to it. As is well-known, our society is aging – thousands of 'Baby Boomers' are turning 65 every day, and it is projected that the Medicare population will reach 70 million in 2030, just over 15 years from now. This dynamic poses immense challenges to the Medicare program and our nation as a whole. Simply put, we *must* explore creative ways that will enable us to keep the promise made to our senior fellow citizens without putting our nation's fiscal future in jeopardy.

I firmly believe that Home Healthcare has an important role to play, and we stand ready to do so. The driving purpose of home health is to help seniors stay healthy at home. The complex, specialized nursing services we deliver every day not only enables our patients to avoid medical complications and return to health – they avoid institutionalization that would substantially increase costs to Medicare and taxpayers. As has been well documented, home healthcare services are significantly less costly to deliver than those in institutional settings. As a result, it's not just that there's no place like home – there's also no place less expensive than home.

Despite the value that skilled home healthcare professionals already provide and the difference we are making in the lives of our patients, we believe we can do even more for the Medicare program and the nation. Our ability to

do so today, however, is constrained by a variety of challenges that serve as obstacles to greater efficiency and even better outcomes. These constraints include:

- A payment system that is so complex and burdensome it borders on nonsensical;
- Unchecked program integrity issues, especially in certain locations that consistently demonstrate aberrant utilization patterns;
- The requirement that a senior must be so infirm as to be deemed homebound before she or he is permitted to receive medical care at home;
- Arbitrary payment cuts that indiscriminately impact vulnerable seniors, women, jobs, small businesses, technology, and our ability to help people stay healthy at home; and,
- A siloed payment system that impedes care coordination and creates bureaucratic obstacles to quality and efficiency.

It is for these reasons that we so appreciate your development and consideration of reforms that can achieve significant improvement in the lives of vulnerable Americans and the Medicare program on which they depend.

The BACPAC proposal is a compelling example of such positive reform. Through the creation of a clinical condition-specific, site-neutral payment model for post acute care services, BACPAC represents a very important step forward for the Medicare program. In contrast to the challenges which compromise post-acute care today, the BACPAC model is designed to:

- Break down the barriers that today impair quality and produce inefficiency;
- Foster care coordination across today's siloes and among multiple providers;
- Enable mobile and homebound seniors alike to remain where they want to be – home;
- Permit investment in technologies and innovations that will lead to truly connected care; and,
- Achieve significant savings that can be utilized for Medicare program improvements such as reform of the Sustainable Growth Rate (SGR) formula.

Among these laudable attributes are three that I believe deserve specific mention.

First, the approach embodied by BACPAC would foster care coordination in a manner that I believe is essential if the Medicare program is to evolve in the best interests of patients and taxpayers alike. Today, there is too little coordination – a problem that begins even prior to a patient's discharge from a hospital and which manifests itself in the weeks and months that follow. Too often, the result is the delivery of care that is less effective, more disjointed, and far more costly than is necessary and which is delivered in a setting and manner that is not preferred by the patient and her or his family.

By contrast, the BACPAC model would foster care coordination across today's post acute care siloes and amongst a broad array of participants, including the hospitalist and discharge planner, the patient's physician, and the many physicians, nurses, therapists and other members of the post-acute care spectrum. BACPAC has the potential to unite these disparate elements due to its establishment of a single site-neutral bundled payment for each distinct clinical condition and its placement of responsibility for management of that bundled payment (and attendant risk assumption) with Coordinators and their comprehensive networks of medical professionals. Free from the artificial barriers that today impede collaboration and connectedness, this model would foster collaborative management of patients within these networks throughout the 90 days following discharge. As indicated by demonstration programs now underway, such a structure can have a transformative effect on patient care and outcomes as well as operational and program efficiency. And as MedPAC has noted, "Bundled payments … encourage providers to coordinate care to focus on managing patient outcomes and controlling costs."[2]

Second among the features I would like to address is innovation. Today, a concerning gulf separates technological advances and their integration into at-home healthcare. Put another way, we are experiencing a real renaissance in the development of technological innovations that can improve patient care, outcomes and safety. As I wrote in the *New England Journal Medicine*, an example of these innovations is the ability of physicians to "arrive at patients' homes with a new version of the black bag that includes a mobile x-ray machine and a device that can

[2] http://www.medpac.gov/documents/20130614_WandM_Testimony_PAC.pdf, p 8.
[2] "Why Health Care Is Going Home" by Steven J. Landers, MD, MPH. *New England Journal of Medicine*. October 21, 2010.

perform more than 20 laboratory tests at the point of care." [2] And yet, antiquated Medicare regulations and payment rules compromise the ability of providers to utilize technologies.

Unfortunately, the Medicare program neither provides support for nor takes into account the cost of such technologies in the home setting. In fact, Medicare does not allow telehealth to be used as a substitute for covered services, provides no funding for telehealth in the home setting, and prohibits home health agencies from even including telehealth expenses in their cost report. As a result, thousands of small home health providers that do not have the resources to undertake efforts similar to ours are unable to make them available to the many seniors they serve. This means, therefore, that the potential for at-home technology is being realized today to a far smaller degree than is possible and optimal.

The BACPAC model can help rectify this problem. By authorizing the use of funds for innovations that can improve outcomes and reduce cost – such as telehealth technologies – BACPAC would bridge the gap that exists today. Further, by placing risk and the potential for gain-sharing with Coordinators and their contracted networks of providers, BACPAC creates a powerful incentive to invest in technological advances precisely because they can do a great deal to reduce cost. As a result, we view this as very positive for patients, providers and, by extension, the fiscal sustainability of the Medicare program as a whole.

Last but absolutely not least, I wish to address the matter of patient choice. As stated previously, home healthcare professionals are dedicated to delivering compassionate, quality medical treatment to seniors so they may stay with their families and in their community. We believe this is vital because we know that it's what seniors want. As AARP has consistently documented, more than 9-in-10 American seniors wish to age in the comfort, safety and dignity of their home – not in an institutional setting. As a result, we believe that seniors' choices must not only be preserved but strengthened in any reform that Congress may contemplate.

In our view, the BACPAC model adheres to this objective. As proposed, this legislation ensures that seniors and their families would be able to exercise the freedom of choice. Specifically, patients would have the freedom to

choose their coordinator and, thus, their network of providers. In addition, patients would also have the freedom to choose from among the providers in their selected coordinator's network. Further, the BACPAC model would actually expand the options available to seniors by reducing some of the unnecessary barriers – like the three-day stay and the homebound requirement. As a result, a patient who, for example, is not homebound but would like to receive medical treatment at home would be able to do so – today, they cannot. We believe this thoughtful approach to post-acute care reform will enable patients to receive the medical treatment they need in the most appropriate setting that they are comfortable in.

Before closing, I would also like to take this opportunity to commend the Committee for its work on related policy priorities. In particular, I would like to thank you for the focus being given to payment reform that would replace the indiscriminate harm being imposed by across-the-board rebasing cut with value-based purchasing that achieves savings via reduced rehospitalizations. Rebasing, as implemented by the Department of Health and Human Services, threatens to undermine the very home healthcare delivery system on which post-acute care reform will depend. Confronted with 3.5 percent annual cuts in 2014, 2015, 2016 and 2017, many providers are being forced to make a decision being closure, consolidation or sale – each of which threatens to limit access to the high-quality, cost-effective home healthcare services that seniors need and prefer. As a result, the focus being given to value-based purchasing as an alternative source of savings is not only superior public policy – it is giving many in my community a reason for hope in an extraordinarily difficult time.

Similarly, your continued focus on program integrity reform is worth special mention. The Partnership has long asserted that change is needed not just to recoup funds that are paid to what we call the "fraudulent fringe" but to prevent the payment of aberrant claims in the first place. To help achieve this outcome, the Partnership developed a tough package of reforms known as the *Skilled Home Healthcare Integrity and Program Savings* (SHHIPS) Act. We are very grateful for the consideration being given its provisions and are hopeful that some if not all of it may be incorporated into future legislation so that the integrity of the program on which our senior citizens depend can be fully assured.

In closing, I would like to thank you again for convening this hearing and the privilege of participating in it. America's seniors deserve a Medicare program that provides high-quality preventive, therapeutic, rehabilitative and palliative care, and they want Medicare to be a program that will not burden their children and grandchildren with unsustainable costs.

These outcomes need not be mutually exclusive – we *can* have a high-quality *and* cost-effective Medicare program, but achieving both outcomes will require thoughtful and transformative reform. I applaud you for tackling the difficult challenge of crafting such reform. I also wish to express our appreciation and respect to Congressman David McKinley and his staff for their extraordinary work on this complex and important issue. Speaking not solely for myself or the Partnership but the home health community as a whole, I wish to assure you we stand ready to serve as a resource in your important work to Keep the Promise for America's seniors.

Thank you.

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Summary

Home Healthcare: Essential to America's Most Vulnerable Seniors

- Today, more than 1 million physicians, nurses, therapists and other caregivers are delivering complex medical services in the homes of the most vulnerable seniors in Medicare.
- The population we serve is documented as being older, poorer, sicker and more likely to be female, minority and disabled than all other Medicare beneficiaries – combined. Examples:
  - Stroke survivor relearning how to walk, talk and eat again.
  - Seniors and disabled Americans with MS, Alzheimer's and complex chronic conditions.
- HH professionals are a ray of light in their lives, delivering medical treatment with compassion, tenderness, and professional skill that enables seniors to stay in their homes and communities.

Home Healthcare: Also Essential to America's Taxpayers and Sustainability of the Medicare Program

- America is aging – 10,000 Boomers entering Medicare every day; 70 million in just 15 years.
- HH is key to helping them remain independent, in the dignity of their homes and communities.
- Our priority is to help seniors stay healthy at home, avoiding costly institutionalization.
- It's not just that there's no place like home – there's also no place less expensive than home.

Home Healthcare: A Vital Tool that Can Do Even More

- Despite the value we already provide and the difference we are making, we can do even more.
- Today, we are burdened by challenges and obstacles to efficiency and even better outcomes:
  - A payment system that is so complex it borders on nonsensical.
  - Program integrity issues, esp. in certain locations with aberrant utilization patterns.
  - The requirement that a senior must be homebound to receive medical care at home.
  - Arbitrary payment cuts that indiscriminately impact vulnerable seniors, women, jobs, small businesses, technology, and our ability to help people stay healthy at home.
  - Siloed payment system that creates bureaucratic obstacles to quality and efficiency.
- It's for these reasons that we are excited about the reforms that you are considering.

Reforms Now Under Consideration Offer Tremendous Promise for Improvement

- BACPAC model offers the potential to address these challenges in a significant way.
  - Breaks down the barriers that today impairs quality and imposes inefficiency.
  - Fosters care coordination across today's siloes and among multiple providers.
  - Enables mobile and homebound seniors alike to remain where they want to be – home.
  - Permits investment in technologies and innovations that will lead to truly connected care.
  - Achieves tens of billions in savings that can be utilized for much-needed SGR reform.
- We also applaud the work being done on other policy priorities, including:
  - Payment reform that would replace the indiscriminate harm being imposed by rebasing with value-based purchasing that achieves savings via reduced rehospitalizations; and
  - Program integrity reform that would stop fraud by preventing payment for aberrant claims.

In closing, Home Health stands ready to help as you embark on this critically important journey, and we look forward to joining you in 'Keeping the Promise' for America's seniors.